Reinstatement of Pharmacist License

FOR BOARD USE ONLY
License No. _____
Date of Expiration _____
Reinstatement Requirements
_____
_____
Fee Paid _____
Approved _____
Date Reinstated _____

MARYLAND STATE BOARD OF PHARMACY
4201 PATTERSON AVENUE
BALTIMORE, MARYLAND 21215-2299
PHONE: (410) 764-4755

PHARMACIST REINSTATEMENT APPLICATION

If applying within 2 years of expiration of license, enclose check for: Reinstatement fee of $65 and Renewal of $150.00 for a total of $215.00.
If applying more than 2 years after expiration of license, enclose check for $80.00 for reinstatement, and $150.00 for renewal, for a total of $230.00.

Make check payable to the Maryland Board of Pharmacy.

Date: _____

1. _____
First Middle and/or Maiden Last Name

_____
Street City State Zip Code

Telephone Number: _____ Social Security #: _____

2. Place of Birth:_____Month_____Day_____Year_____Age_____Sex:____Race:____

3. Graduate of (School of Pharmacy)_____

Date: _____ Degree:_____

4. Maryland License #: _____ by ( ) Examination ( ) Reciprocity was originally issued on

_____.
(Date)

5. List all other pharmacist licenses ever received:

State: _____ License #:_____Date issued:_____in good standing _____yes _____no

State:_____ License #:_____Date issued:_____in good standing _____yes _____no

State:_____ License #:_____Date issued:_____in good standing _____yes _____no

State:_____ License #:_____Date issued:_____in good standing _____yes _____no

6. List work experience as a licensed pharmacist for the past 2 years: Name and address of Pharmacy and period of service. Attach additional sheets if needed.

a. _____ b. _____

_____ _____

From _____ to _____ **From _____ to _____**

FOR THE FOLLOWING, ATTACH A DETAILED EXPLANATION FOR EACH QUESTION ANSWERED YES

7. **Have you been addicted to the use of drugs or alcohol with the results that your ability to practice your profession has been impaired?**
( ) Yes ( ) No

8. **(a) Has any State Licensing or Disciplinary Board or a comparable body in the Armed Service, denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, or revocation?**
( ) Yes ( ) No

(b) Have you surrendered or failed to renew a license in any State?
( ) Yes ( ) No

9. **Are there any outstanding complaints, investigations or charges pending against you in any state by any Licensing or Disciplinary Board, or a comparable body in the Armed Services?**
( ) Yes ( ) No

10. **Have you have a physical or mental illness that currently impairs your ability to practice your profession?**
( ) Yes ( ) No

11. **Have you plead guilty, nolo contendere, or been convicted of, or received probation before judgment or any criminal act (excluding traffic violations)?**
( ) Yes ( ) No

12. **Have you pled guilty, nolo contendere, or been convicted of, or received probation before judgment of driving while intoxicated or of a controlled dangerous substance offense?**
( ) Yes ( ) No

13. **Please briefly explain (use other paper if needed) why you gave up your license and are now requesting it back_____**

14. **I, _____, do solemnly swear or affirm, under the penalties of perjury that I have personally completed this application, that the forgoing information is true, correct and complete to the best of my knowledge and belief, and that I have read the Maryland Pharmacy Act, Health Occupations Article, Section 12-309 et seq. Of the Annotated Code of Maryland and regulations promulgated by the Board and agree to practice pharmacy in accordance with laws of Maryland.**

_____
Applicant s full signature

PLEASE READ REGULATION 10.34.13 - REINSTATEMENT OF EXPIRED LICENSES FOR PHARMACISTS TO DETERMINE THE SPECIFIC REQUIREMENTS THAT YOU MUST COMPLETE TO QUALIFY FOR REINSTATEMENT OF YOUR LICENSE TO PRACTICE PHARMACY.

4201 Patterson Avenue
Baltimore, Maryland 21215

PHARMACY EXPERIENCE AFFIDAVIT
(Please Fill In All Blank Spaces)

State of _____; County or City of _____

I, the undersigned, hereby certify that I am a licensed Pharmacist in the State of

_____, Certificate No. _____; and that
(Supervising Pharmacist)

_____, received practical pharmacy experience as follows:
(Applicant s Name)

HOURS OF EXPERIENCE

From _____ to_____ # of Weeks _____ x Hours per Week _____ = Hours Earned

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From _____ to_____ # of Weeks _____ x Hours per Week _____ = Hours Earned

TOTAL HOURS reported on the form: _____

I, _____, do solemnly swear or affirm, under the penalties of
(Supervising Pharmacist)
perjury, that I have personally completed this form to the best of my knowledge and belief, that I understand that perjury on this form will constitute grounds for revoking any license issued which uses this form as a supporting document.

SIGNATURE: _____

PHARMACY: _____

ADDRESS: _____

A.D., 20____

IMPORTANT NOTICE: This affidavit must be notarized and submitted with application for reinstatement where appropriate.

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